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# Tiotropium and olodaterol fixed-dose combination *versus* mono-components in COPD (GOLD 2–4)

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**ABSTRACT** Efficacy and safety of tiotropium+olodaterol fixed-dose combination (FDC) compared with the mono-components was evaluated in patients with moderate to very severe chronic obstructive pulmonary disease (COPD) in two replicate, randomised, double-blind, parallel-group, multicentre, phase III trials.

Patients received tiotropium+olodaterol FDC 2.5/5 µg or 5/5 µg, tiotropium 2.5 µg or 5 µg, or olodaterol 5 µg delivered once-daily *via* Respimat inhaler over 52 weeks. Primary end points were forced expiratory volume in 1 s (FEV<sub>1</sub>) area under the curve from 0 to 3 h (AUC<sub>0–3</sub>) response, trough FEV<sub>1</sub> response and St George's Respiratory Questionnaire (SGRQ) total score at 24 weeks.

In total, 5162 patients (2624 in Study 1237.5 and 2538 in Study 1237.6) received treatment. Both FDCs significantly improved FEV<sub>1</sub> AUC<sub>0–3</sub> and trough FEV<sub>1</sub> response *versus* the mono-components in both studies. Statistically significant improvements in SGRQ total score *versus* the mono-components were only seen for tiotropium+olodaterol FDC 5/5 µg. Incidence of adverse events was comparable between the FDCs and the mono-components.

These studies demonstrated significant improvements in lung function and health-related quality of life with once-daily tiotropium+olodaterol FDC *versus* mono-components over 1 year in patients with moderate to very severe COPD.



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## Introduction

Long-acting bronchodilators, such as long-acting muscarinic antagonists (LAMAs), are the cornerstone of maintenance therapy for patients with moderate to very severe chronic obstructive pulmonary disease (COPD) whose symptoms are not adequately controlled by short-acting bronchodilators alone [1, 2].

Tiotropium is an established once-daily LAMA that improves the main functional and patient-orientated outcomes of COPD [3–8]. Tiotropium has also been demonstrated to moderate disease progression, even in the early stages of COPD (e.g. patients not receiving maintenance therapy [9] or those with Global initiative for chronic Obstructive Lung Disease (GOLD) stage 2 disease [10]).

The novel once-daily long-acting  $\beta_2$ -agonist (LABA) olodaterol is a highly selective and nearly full  $\beta_2$  agonist [11, 12] that provides 24-h bronchodilation in patients with COPD [13–16]. Olodaterol is also associated with symptomatic benefit [17] and enhanced exercise capacity [18].

An option recommended by GOLD for patients not adequately controlled on a single long-acting bronchodilator is to combine a LAMA with a LABA [2]. This has prompted the development of combining LAMA+LABA as fixed-dose combinations (FDCs) [1]. The complementary modes of action of tiotropium and olodaterol have previously been demonstrated in animal models and phase II clinical trials [19–22].

We hypothesised that combination therapy with tiotropium+olodaterol FDC would provide improvements in lung function, health-related quality of life and other COPD disease parameters compared to monotherapy with either component alone, with a comparable safety profile. These two replicate, global, phase III trials (TONado 1 and 2) aimed to assess the efficacy and safety of once-daily treatment with orally inhaled tiotropium+olodaterol FDC 5/5  $\mu\text{g}$  or 2.5/5  $\mu\text{g}$  delivered *via* the Respimat Soft Mist Inhaler (Boehringer Ingelheim, Ingelheim am Rhein, Germany) compared with their individual mono-components in patients with moderate to very severe COPD (GOLD stage 2–4) over 52 weeks.

## Methods

### Study design

These were multinational, replicate, phase III, multicentre, randomised, double-blind, active-controlled, five-arm, parallel-group studies, registered with ClinicalTrials.gov (Study 1237.5: NCT01431274; Study 1237.6: NCT01431287) (fig. 1). Three primary end points were evaluated after 24 weeks of treatment: forced expiratory volume in 1 s (FEV<sub>1</sub>) area under the curve from 0 to 3 h (AUC<sub>0–3</sub>) response (in each individual trial), trough FEV<sub>1</sub> response in each individual trial (response defined as change from baseline; mean of the values of 1 h and 10 min prior to the first dose of study medication); and St George's Respiratory Questionnaire (SGRQ) total score (SGRQ was analysed in a pre-specified combined analysis of data from both studies). Pulmonary function tests (PFTs) were performed on day 1 and at weeks 2, 6, 12, 18, 24, 32, 40 and 52. SGRQ was completed on day 1 and after 12, 24 and 52 weeks, prior to PFTs and all other procedures. Details of the study design, assessments performed and statistical methodology are provided in table S1 of the online supplementary material.

Patients continued to receive treatment with inhaled corticosteroids as required and were provided with salbutamol/albuterol metered-dose inhaler (100  $\mu\text{g}$  per actuation) as rescue medication to be used as necessary at any point during the trial. Temporary increases in the dose or addition of oral steroids or theophylline preparations were allowed during the treatment portion of the study; PFTs were not performed within 7 days of the last administered dose.

### Patients

Patients were randomised if they met the following main inclusion criteria: outpatients aged  $\geq 40$  years with a history of moderate to very severe COPD (GOLD stage 2–4) [23]; post-bronchodilator FEV<sub>1</sub> <80% of predicted normal; post-bronchodilator FEV<sub>1</sub>/forced vital capacity (FVC) <70%; current or ex-smokers with a smoking history of >10 pack-years.

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Clinical trials: These studies are registered at [www.clinicaltrials.gov](http://www.clinicaltrials.gov) with identifier numbers NCT01431274 and NCT01431287, and Boehringer Ingelheim study numbers 1237.5 and 1237.6.

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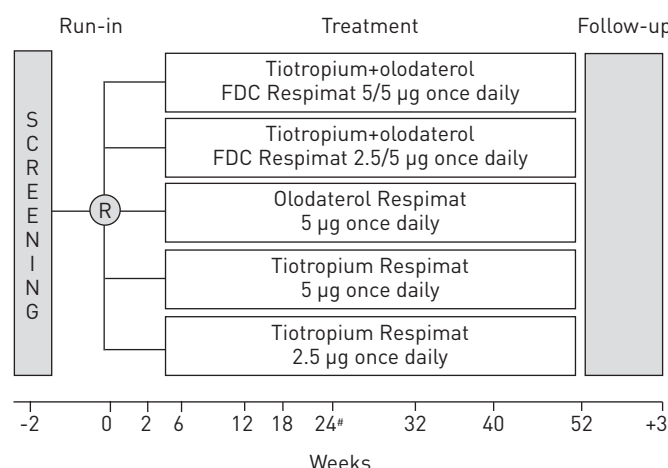


FIGURE 1 Study design (Study 1237.5: NCT01431274; Study 1237.6: NCT01431287). R: randomisation; FDC: fixed-dose combination. #: primary end-point assessment.

Patients with a significant disease other than COPD were excluded from the trials. Other exclusion criteria included: clinically relevant abnormal baseline laboratory parameters or a history of asthma; myocardial infarction within 1 year of screening; unstable or life-threatening cardiac arrhythmia; known active tuberculosis; clinically evident bronchiectasis; cystic fibrosis or life-threatening pulmonary obstruction; hospitalised for heart failure within the past year; diagnosed thyrotoxicosis or paroxysmal tachycardia; previous thoracotomy with pulmonary resection; regular use of daytime oxygen if patients were unable to abstain during clinic visits; or currently enrolled in a pulmonary rehabilitation programme (or completed in the 6 weeks before screening).

Patients with moderate or severe renal impairment (creatinine clearance  $\leq 50$  mL·min<sup>-1</sup>) were not excluded from the study but were closely monitored by the investigator.

Both studies were performed in accordance with the Declaration of Helsinki, International Conference on Harmonisation Harmonised Tripartite Guideline for Good Clinical Practice and local regulations. The protocols were approved by the authorities and the ethics committees of the respective institutions, and signed informed consent was obtained from all patients.

## Results

### *Patient disposition and baseline characteristics*

A total of 5163 patients (2624 Study 1237.5; 2539 Study 1237.6) were randomised to receive treatment in 25 countries; 5162 patients were treated (2624 Study 1237.5; 2538 Study 1237.6). Overall, 84.6% of patients (86.2% Study 1237.5; 83.0% Study 1237.6) completed the studies. The discontinuation rate was higher in the monotherapy than the combination treatment groups in both studies (fig. 2). The data for the individual studies are presented in the online supplementary material.

Baseline demographics were generally similar across treatment groups. The majority of patients were male (72.9% total) and approximately one-third were current smokers. Most patients were classified as GOLD stage 2/3 (88.6%); the remaining patients (11.3%) were classified as GOLD stage 4. Overall, 86.4% of patients had diagnosed co-morbidities at baseline; 1107 (21.4%) had cardiac disorders and 2481 (48.1%) had vascular disorders including hypertension (table 1, and table S2 in the online supplementary material for individual study data).

### *Efficacy*

#### *Lung function*

FEV<sub>1</sub> AUC<sub>0-3</sub> responses for tiotropium+olodaterol FDC 2.5/5 µg, 5/5 µg, tiotropium 2.5 µg, 5 µg and olodaterol 5 µg were 241, 256, 148, 139 and 133 mL, respectively, in Study 1237.5, and 256, 268, 125, 165 and 136 mL, respectively, in Study 1237.6. Improvements in adjusted mean FEV<sub>1</sub> AUC<sub>0-3</sub> with tiotropium+olodaterol FDC 5/5 µg and 2.5/5 µg over the corresponding individual components in the individual studies and the combined analysis were statistically significant ( $p < 0.0001$  for all comparisons) (table 2, and table S3 in the online supplementary material). The comparison of tiotropium+olodaterol FDC 2.5/5 µg with tiotropium 5 µg (performed to compare the combination with the licensed tiotropium dose) was  $p < 0.0001$  for all analyses.

Trough FEV<sub>1</sub> responses after 24 weeks for tiotropium+olodaterol FDC 2.5/5 µg, 5/5 µg, tiotropium 2.5 µg, 5 µg and olodaterol 5 µg were 111, 136, 83, 65 and 54 mL, respectively, in Study 1237.5, and 125, 145, 62, 96 and 57 mL, respectively, in Study 1237.6. Improvements in the adjusted mean trough FEV<sub>1</sub> with

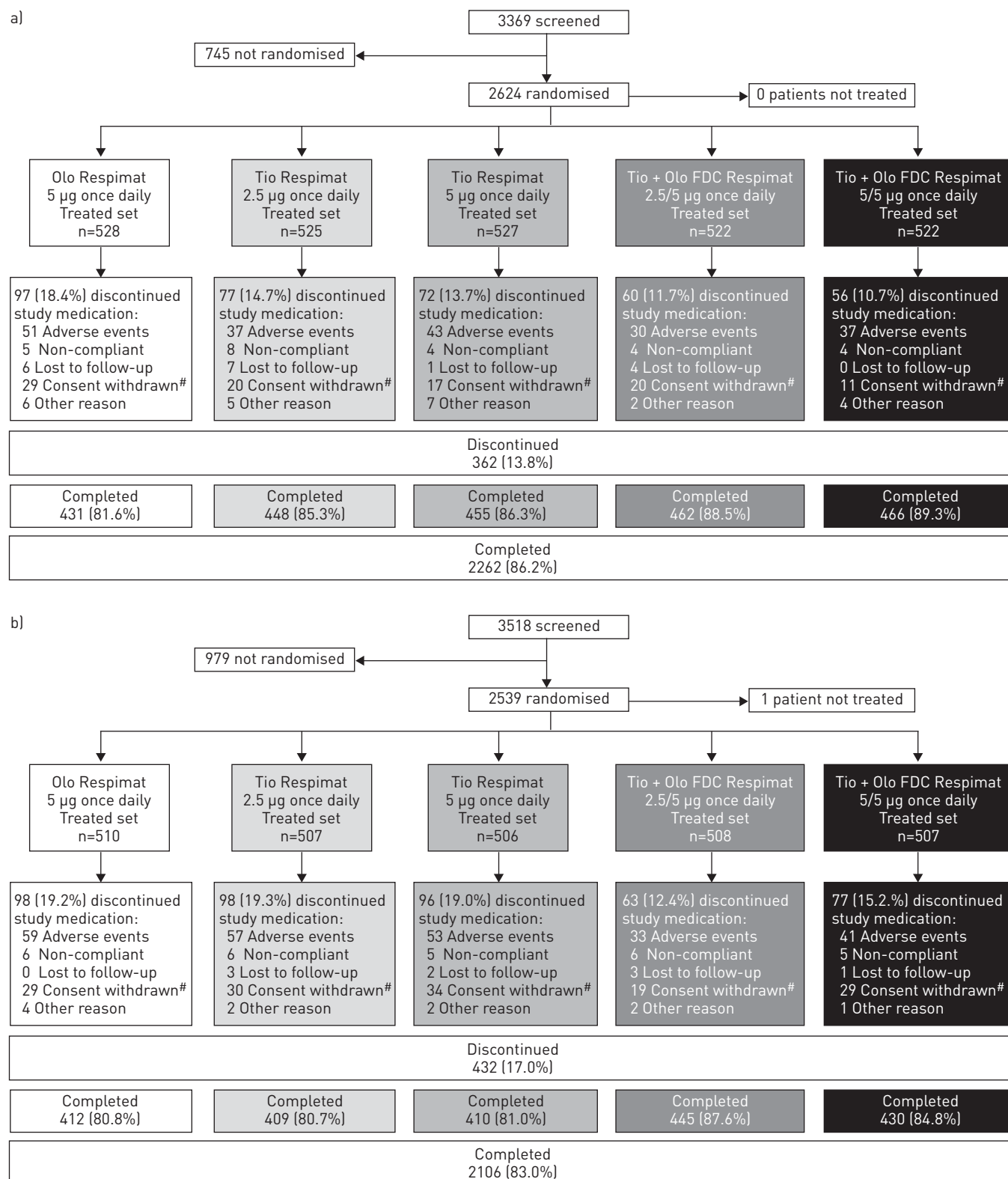


FIGURE 2 Patient disposition and flow in (a) Study 1237.5 and (b) Study 1237.6. Tio: tiotropium; Olo: olodaterol; FDC: fixed-dose combination. #: not due to adverse event.

tiotropium+olodaterol FDC 5/5 µg and 2.5/5 µg over the corresponding individual components in both the individual studies and the combined data were statistically significant ( $p < 0.05$  for all comparisons) (table 2, and table S3 in the online supplementary material).

TABLE 1 Demographic and baseline patient characteristics (treated population): combined data (n=5162)

	Olodaterol 5 µg	Tiotropium 2.5 µg	Tiotropium 5 µg	Tiotropium+olodaterol 2.5/5 µg	Tiotropium+olodaterol 5/5 µg
<b>Participants n</b>	1038	1032	1033	1030	1029
<b>Male</b>	764 (73.6)	753 (73.0)	755 (73.1)	757 (73.5)	733 (71.2)
<b>Age years</b>	64.2±8.2	64.0±8.7	63.9±8.6	64.1±7.8	63.8±8.3
<b>Smoking status</b>					
Ex-smoker	660 (63.6)	644 (62.4)	663 (64.2)	658 (63.9)	629 (61.1)
Current smoker	378 (36.4)	388 (37.6)	370 (35.8)	372 (36.1)	400 (38.9)
<b>Co-morbidities</b>					
Cardiac	897 (86.4)	884 (85.7)	902 (87.3)	889 (86.3)	890 (86.5)
Vascular	234 (22.5)	212 (20.5)	219 (21.2)	229 (22.2)	213 (20.7)
<b>Pre-bronchodilator screening FEV<sub>1</sub> mL</b>	1209±505	1218±489	1200±504	1208±473	1180±493
<b>Post-bronchodilator screening FEV<sub>1</sub> mL</b>	1377±520	1393±511	1370±521	1385±496	1344±505
Change from pre- to post-bronchodilator FEV <sub>1</sub> mL	168±143	174±150	171±146	177±138	164±148
FEV <sub>1</sub> /FVC %	45.0±11.6	45.1±11.6	45.0±12.0	44.6±11.5	45.1±11.6
FEV <sub>1</sub> % predicted	50.3±15.6	50.3±15.0	49.7±15.7	50.2±14.9	49.3±15.3
<b>GOLD stage<sup>#</sup></b>					
1 (FEV <sub>1</sub> ≥80% pred)	0 (0.0)	1 (0.1)	1 (0.1)	1 (0.1)	0 (0.0)
2 (FEV <sub>1</sub> 50–<80% pred)	532 (51.3)	518 (50.2)	517 (50.0)	519 (50.4)	502 (48.8)
3 (FEV <sub>1</sub> 30–<50% pred)	378 (36.4)	409 (39.6)	387 (37.5)	407 (39.5)	408 (39.7)
4 (FEV <sub>1</sub> <30% pred)	128 (12.3)	103 (10.0)	128 (12.4)	103 (10.0)	119 (11.6)
<b>Baseline pulmonary medication</b>					
SAMA <sup>¶</sup>	134 (12.9)	140 (13.6)	131 (12.7)	135 (13.1)	125 (12.1)
LAMA <sup>+</sup>	365 (35.2)	348 (33.7)	346 (33.5)	403 (39.1)	378 (36.7)
SABA <sup>§</sup>	424 (40.8)	433 (42.0)	401 (38.8)	421 (40.9)	400 (38.9)
LABA <sup>f</sup>	491 (47.3)	475 (46.0)	450 (43.6)	491 (47.7)	486 (47.2)
ICS <sup>##</sup>	505 (48.7)	476 (46.1)	466 (45.1)	493 (47.9)	506 (49.2)
Xanthines <sup>¶¶</sup>	96 (9.2)	94 (9.1)	109 (10.6)	109 (10.6)	108 (10.5)
<b>Baseline cardiovascular medication</b>					
β-blockers	620 (59.7)	580 (56.2)	596 (57.7)	599 (58.2)	581 (56.5)
	102 (9.8)	119 (11.5)	109 (10.6)	117 (11.4)	110 (10.8)

Data are presented as n (%) or mean±SD, unless otherwise stated. FEV<sub>1</sub>: forced expiratory volume in 1 s; FVC: forced vital capacity; GOLD: Global initiative for chronic Obstructive Lung Disease; SAMA: short-acting muscarinic antagonist; LAMA: long-acting muscarinic antagonist; SABA: short-acting β-agonist; LABA: long-acting β<sub>2</sub>-agonist; ICS: inhaled corticosteroid. <sup>#</sup>: based on post-bronchodilator FEV<sub>1</sub> percentage predicted. In Study 1237.6, 1 patient on tiotropium 2.5 µg was not categorised; <sup>¶</sup>: ipratropium, ipratropium/fenoterol or ipratropium/salbutamol, oxitropin; <sup>+</sup>: tiotropium; <sup>§</sup>: all patients received SABAs as rescue medication; <sup>f</sup>: including arformoterol, formoterol, indacaterol, fenoterol and salmeterol; <sup>##</sup>: including beclomethasone, budesonide, ciclesonide, mometasone furoate/formoterol fumarate hihydrate, fluticasone, formoterol/beclomethasone, formoterol/budesonide, mometasone, mometasone furoate, salmeterol/fluticasone; <sup>¶¶</sup>: including aminophylline, theophylline.

There was no influence of sex on either FEV<sub>1</sub> AUC<sub>0–3</sub> or trough FEV<sub>1</sub> response. An analysis of FEV<sub>1</sub> AUC<sub>0–3</sub> and trough FEV<sub>1</sub> response according to baseline disease severity showed that responses were lower in patients with more severe disease (table S4 in the online supplementary material).

An analysis of FEV<sub>1</sub> AUC<sub>0–3</sub> and trough FEV<sub>1</sub> according to inhaled corticosteroid use is presented in table 3. This confirms that tiotropium+olodaterol improves lung function whether patients were receiving inhaled corticosteroid or not.

Improvements were observed for FEV<sub>1</sub> values on all test days over each of the 52-week studies (fig. 3a and b, and fig. S1 in the online supplementary material). Responses in trough FVC and FVC AUC<sub>0–3</sub> over 24 weeks of treatment were in line with the primary end points (table S5 in the online supplementary material).

#### Health status and symptomatic benefit

After 24 weeks, the pre-specified analysis of the adjusted mean SGRQ total score (table 4) revealed statistically significant improvements for tiotropium+olodaterol FDC 5/5 µg over corresponding individual components (*versus* olodaterol 5 µg: −1.693 (0.553), *p*<0.01; *versus* tiotropium 5 µg: −1.233 (0.551), *p*<0.05) but not for tiotropium+olodaterol FDC 2.5/5 µg *versus* the individual components (table 5).

Responder rates for SGRQ total scores after 24 weeks for the combined data set (responders defined as decrease in SGRQ total score ≥4.0 units, minimum clinically important difference) were: tiotropium

TABLE 2 FEV<sub>1</sub> AUC<sub>0-3</sub> and trough FEV<sub>1</sub> responses (*i.e.* change from baseline) after 24 weeks of treatment (full analysis set) in Studies 1237.5 and 1237.6 separately

Treatment comparison	FEV <sub>1</sub> AUC <sub>0-3</sub> <sup>#</sup> L	p-value	Trough FEV <sub>1</sub> <sup>‡</sup> L	p-value
<b>Study 1237.5 common study baseline</b>	1.158±0.010		1.161±0.010	
Tiotropium+olodaterol 5/5 µg				
<i>versus</i> olodaterol 5 µg	0.123±0.012 [0.100–0.146]	<0.0001	0.082±0.012 [0.059–0.106]	<0.0001
<i>versus</i> tiotropium 5 µg	0.117±0.012 [0.094–0.140]	<0.0001	0.071±0.012 [0.047–0.094]	<0.0001
Tiotropium+olodaterol 2.5/5 µg				
<i>versus</i> olodaterol 5 µg	0.109±0.012 [0.086–0.132]	<0.0001	0.058±0.012 [0.034–0.081]	<0.0001
<i>versus</i> tiotropium 2.5 µg	0.093±0.012 [0.070–0.116]	<0.0001	0.029±0.012 [0.005–0.052]	0.0174
<i>versus</i> tiotropium 5 µg	0.102±0.012 [0.080–0.125]	<0.0001	0.046±0.012 [0.023–0.070]	0.0001
Tiotropium+olodaterol 5/5 µg				
<i>versus</i> tiotropium+olodaterol 2.5/5 µg	0.014±0.012 [-0.008–0.037]	0.2169	0.024±0.012 [0.001–0.048]	0.0407
<b>Study 1237.6 common study baseline</b>	1.150±0.010		1.150±0.010	
Tiotropium+olodaterol 5/5 µg				
<i>versus</i> olodaterol 5 µg	0.132±0.013 [0.108–0.157]	<0.0001	0.088±0.013 [0.063–0.113]	<0.0001
<i>versus</i> tiotropium 5 µg	0.103±0.012 [0.078–0.127]	<0.0001	0.050±0.013 [0.024–0.075]	0.0001
Tiotropium+olodaterol 2.5/5 µg				
<i>versus</i> olodaterol 5 µg	0.121±0.012 [0.096–0.145]	<0.0001	0.067±0.013 [0.042–0.092]	<0.0001
<i>versus</i> tiotropium 2.5 µg	0.131±0.012 [0.106–0.155]	<0.0001	0.062±0.013 [0.037–0.087]	<0.0001
<i>versus</i> tiotropium 5 µg	0.091±0.012 [0.066–0.115]	<0.0001	0.029±0.013 [0.004–0.054]	0.0231
Tiotropium+olodaterol 5/5 µg				
<i>versus</i> tiotropium+olodaterol 2.5/5 µg	0.012±0.012 [-0.013–0.036]	0.3394	0.021±0.013 [-0.004–0.046]	0.1073

Data are presented as adjusted mean±SE [95% CI], unless otherwise stated. Adjusted means were obtained from fitting a mixed model for repeated measurements, including fixed effects of treatment, planned test day, treatment-by-test-day interaction, baseline and baseline-by-test-day interaction; patient as a random effect; spatial power covariance structure for within-patient errors and Kenward–Roger approximation of denominator degrees of freedom. FEV<sub>1</sub>: forced expiratory volume in 1 s; AUC<sub>0-3</sub>: area under the curve from 0 to 3 h.

<sup>#</sup>: number of patients contributing to the mixed model for repeated measurements for adjusted mean FEV<sub>1</sub> AUC<sub>0-3</sub> Study 1237.5: tiotropium+olodaterol 5/5 µg n=522, tiotropium+olodaterol 2.5/5 µg n=521, tiotropium 5 µg n=526, tiotropium 2.5 µg n=524, olodaterol 5 µg n=525; Study 1237.6: tiotropium+olodaterol 5/5 µg n=502, tiotropium+olodaterol 2.5/5 µg n=506, tiotropium 5 µg n=500, tiotropium 2.5 µg n=504, olodaterol 5 µg n=507. <sup>‡</sup>: number of patients contributing to the mixed model for repeated measurements for adjusted mean trough FEV<sub>1</sub> Study 1237.5: tiotropium+olodaterol 5/5 µg n=521, tiotropium+olodaterol 2.5/5 µg n=518, tiotropium 5 µg n=520, tiotropium 2.5 µg n=519, olodaterol 5 µg n=519; Study 1237.6: tiotropium+olodaterol 5/5 µg n=497, tiotropium+olodaterol 2.5/5 µg n=500, tiotropium 5 µg n=498, tiotropium 2.5 µg n=499, olodaterol 5 µg n=503.

+olodaterol FDC 5/5 µg, 57.5%; tiotropium+olodaterol FDC 2.5/5 µg, 53.2%, and responder rates of 49.6%, 48.7% and 44.8% for tiotropium 2.5 µg, 5 µg and olodaterol 5 µg, respectively. The increases in responder rate for tiotropium+olodaterol FDC 5/5 µg over its individual components were statistically significant (nominal p<0.05), and for tiotropium+olodaterol FDC 2.5/5 µg there was a significant improvement in responder rate *versus* olodaterol 5 µg and tiotropium 5 µg but not tiotropium 2.5 µg (table 5).

The pre-specified analysis of the key secondary end point (Mahler Transition Dyspnoea Index focal score at 24 weeks (combined data set)) showed statistically significant improvements for both tiotropium+olodaterol FDCs *versus* their mono-components (nominal p<0.05) (table S6 in the online supplementary material).

#### Rescue medication

Both tiotropium+olodaterol FDC 5/5 µg and 2.5/5 µg provided reductions in adjusted weekly mean daily (24-h) rescue medication use compared to the monotherapy components throughout the 52-week treatment period (fig. S2 in the online supplementary material).

#### Exacerbations

Figure S3 in the online supplementary material shows Kaplan–Meier estimates of probability of moderate/severe COPD exacerbation. There was a trend for improvement in exacerbations with both FDCs *versus* the monotherapy components.

#### Safety

Table 6 shows a summary of adverse events for the combined data set (for Studies 1237.5 and 1237.6, see table S7 in the online supplementary material). Adverse event incidence was generally balanced across all treatment groups, with the majority being mild to moderate in severity. The proportion of patients who

TABLE 3 FEV<sub>1</sub> AUC<sub>0-3</sub> and trough FEV<sub>1</sub> responses (*i.e.* change from baseline) after 24 weeks of treatment by ICS usage (full analysis set, combined data)

Treatment comparison	ICS usage			
	Yes		No	
	Adjusted mean±SE (95% CI)	p-value	Adjusted mean±SE (95% CI)	p-value
<b>FEV<sub>1</sub> AUC<sub>0-3</sub>L</b>				
Common study baseline	1.073±0.009		1.226±0.010	
Tiotropium+olodaterol 5/5 µg				
<i>versus</i> olodaterol 5 µg	0.131±0.012 [0.107–0.154]	<0.0001	0.125±0.012 [0.101–0.148]	<0.0001
<i>versus</i> tiotropium 5 µg	0.113±0.012 [0.089–0.137]	<0.0001	0.108±0.012 [0.085–0.132]	<0.0001
Tiotropium+olodaterol 2.5/5 µg				
<i>versus</i> olodaterol 5 µg	0.117±0.012 [0.093–0.141]	<0.0001	0.113±0.012 [0.090–0.137]	<0.0001
<i>versus</i> tiotropium 2.5 µg	0.104±0.012 [0.080–0.128]	<0.0001	0.120±0.012 [0.096–0.143]	<0.0001
<i>versus</i> tiotropium 5 µg	0.099±0.012 [0.075–0.123]	<0.0001	0.097±0.012 [0.074–0.120]	<0.0001
Tiotropium+olodaterol 5/5 µg				
<i>versus</i> tiotropium+olodaterol 2.5/5 µg	0.014±0.012 [–0.010–0.037]	0.2533	0.012±0.012 [–0.012–0.035]	0.3342
<b>Trough FEV<sub>1</sub> L</b>				
Common study baseline	1.075±0.009		1.227±0.010	
Tiotropium+olodaterol 5/5 µg				
<i>versus</i> olodaterol 5 µg	0.087±0.012 [0.063–0.111]	<0.0001	0.082±0.013 [0.057–0.107]	<0.0001
<i>versus</i> tiotropium 5 µg	0.045±0.012 [0.021–0.070]	0.0003	0.076±0.012 [0.052–0.100]	<0.0001
Tiotropium+olodaterol 2.5/5 µg				
<i>versus</i> olodaterol 5 µg	0.068±0.012 [0.044–0.092]	<0.0001	0.056±0.013 [0.031–0.080]	<0.0001
<i>versus</i> tiotropium 2.5 µg	0.030±0.012 [0.006–0.055]	0.0155	0.060±0.012 [0.036–0.084]	<0.0001
<i>versus</i> tiotropium 5 µg	0.026±0.013 [0.001–0.050]	0.0385	0.050±0.012 [0.025–0.074]	<0.0001
Tiotropium+olodaterol 5/5 µg				
<i>versus</i> tiotropium+olodaterol 2.5/5 µg	0.019±0.012 [–0.005–0.043]	0.1134	0.026±0.013 [0.002–0.051]	0.0369

FEV<sub>1</sub>: forced expiratory volume in 1 s; AUC<sub>0-3</sub>: area under the curve from 0 to 3 h; ICS: inhaled corticosteroid.

reported at least one adverse event while on treatment was 74.4%. Overall, 6.4% of adverse events were deemed treatment related; rates of serious adverse events were broadly similar across treatment arms. Rates of serious adverse events were 16.4%, with fatality rates of 1.5%. The majority of treatment-emergent adverse events (incidence of >3%) were respiratory events, in particular COPD exacerbations and infections according to Medical Dictionary for Regulatory Activities (MedDRA) classifications. A higher proportion of patients in the tiotropium+olodaterol FDC 2.5/5 µg arm experienced upper respiratory infections while on treatment compared with the other arms. Respiratory events (including COPD exacerbations) were more frequent among patients treated with monotherapies. No significant abnormalities in vital signs or laboratory parameters were observed in either study.

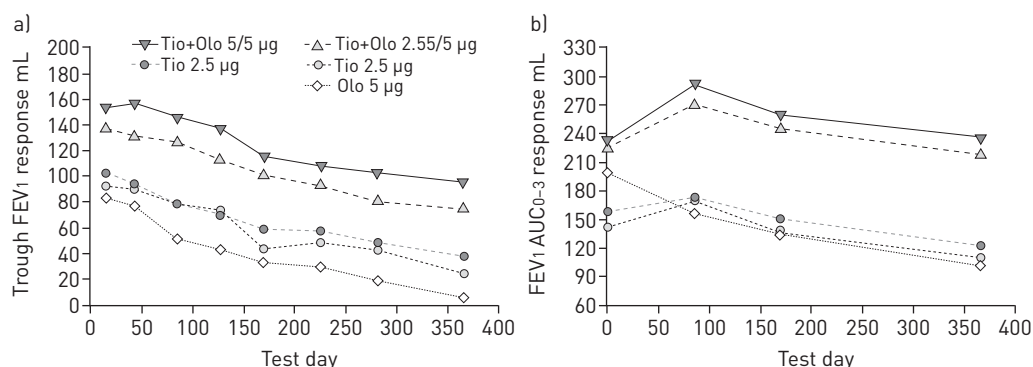


FIGURE 3 Lung function end points (combined data set) over 52 weeks: full analysis set. a) adjusted mean trough forced expiratory volume in 1 s (FEV<sub>1</sub>); all comparisons of Tio+Olo 5/5 µg and 2.5/5 µg *versus* the monotherapies were statistically significant ( $p < 0.05$ ) with the exception of Tio+Olo 2.5/5 µg *versus* Tio 2.5 µg at day 43. b) FEV<sub>1</sub> area under the curve from 0 to 3 h (AUC<sub>0-3</sub>); all comparisons of Tio+Olo 5/5 µg and 2.5/5 µg *versus* the monotherapies were statistically significant ( $p < 0.01$ ). Tio: tiotropium; Olo: olodaterol.



TABLE 4 St George's Respiratory Questionnaire (SGRQ) score at 24 weeks (full analysis set)

	SGRQ total score <sup>#</sup>	SGRQ responders <sup>¶</sup>
<b>Studies 1237.5+1237.6 common study baseline</b>	43.512±0.259	
Olodaterol 5 µg	38.366±0.396	427/954 (44.8)
Tiotropium 2.5 µg	37.792±0.390	476/960 (49.6)
Tiotropium 5 µg	37.907±0.393	465/955 (48.7)
Tiotropium+olodaterol 2.5/5 µg	37.335±0.385	527/990 (53.2)
Tiotropium+olodaterol 5/5 µg	36.674±0.386	563/979 (57.5)

Data are presented as adjusted mean±SE or n/N (%). Data were obtained from fitting a mixed model for repeated measurements including fixed effects of treatment, planned test day, treatment-by-test-day interaction, baseline and baseline-by-test-day interaction; patient as a random effect; spatial power covariance structure for within-patient errors and Kenward–Roger approximation of denominator degrees of freedom. <sup>#</sup>: number of patients contributing to the mixed model for repeated measurements for adjusted mean SGRQ across both studies: tiotropium+olodaterol 5/5 µg n=979; tiotropium+olodaterol 2.5/5 µg n=990; tiotropium 5 µg n=954; tiotropium 2.5 µg n=960; olodaterol 5 µg n=954; <sup>¶</sup>: defined as having an SGRQ total score at week 24 ≥4.0-times better than baseline SGRQ total score.

Overall incidence of adverse events in the subset of patients with cardiac history was broadly comparable (78.1%, 75.8%, 79.0%, 80.6% and 79.7% in the tiotropium+olodaterol FDC 5/5 µg, tiotropium+olodaterol FDC 2.5/5 µg, tiotropium 2.5 µg, 5 µg and olodaterol 5 µg groups, respectively). Rate ratios for major adverse cardiac events (MACE) and “cardiac disorders” System Organ Class (SOC) are presented in table S8 of the online supplementary material, which demonstrates that the incidences of these events were similar with the FDCs and individual components.

## Discussion

This pair of replicate, 52-week studies of the effects of once-daily combination of tiotropium+olodaterol administered *via* the Respimat Soft Mist Inhaler in patients with moderate to very severe COPD confirm statistically significant increases for the primary lung-function end points of trough FEV<sub>1</sub> and FEV<sub>1</sub> AUC<sub>0-3</sub> response after 24 weeks *versus* either tiotropium or olodaterol alone. These results are supported by a range of secondary lung-function end points over 52 weeks. FEV<sub>1</sub> AUC<sub>0-3</sub> and trough FEV<sub>1</sub> reflect bronchodilator benefit at the beginning and end of a 24-h cycle and are important measures in the selection of optimum doses and dosing frequency.

Long-acting bronchodilators remain the cornerstone of COPD maintenance therapy [2]. However, the combination of bronchodilators with different modes of action has not been commonly prescribed in

TABLE 5 St George's Respiratory Questionnaire (SGRQ) score at 24 weeks (full analysis set): treatment comparisons

Treatment comparison	SGRQ total score <sup>#</sup>	p-value	Responder analysis <sup>¶</sup> odds ratio <sup>§, f</sup>	p-value
<b>Tiotropium+olodaterol 5/5 µg</b>				
<i>versus</i> olodaterol 5 µg	−1.693±0.553 [−2.778–0.608]	0.0022	1.670±0.153 (1.395–1.999)	<0.0001
<i>versus</i> tiotropium 5 µg	−1.233±0.551 [−2.313–0.153]	0.0252	1.426±0.131 (1.192–1.706)	0.0001
<b>Tiotropium+olodaterol 2.5/5 µg</b>				
<i>versus</i> olodaterol 5 µg	−1.031±0.552 [−2.113–0.052]	0.0620	1.405±0.128 (1.175–1.679)	0.0002
<i>versus</i> tiotropium 2.5 µg	−0.456±0.548 [−1.531–0.618]	0.4051	1.157±0.105 (0.969–1.383)	0.1071
<i>versus</i> tiotropium 5 µg	−0.571±0.550 [−1.649–0.507]	0.2988	1.199±0.109 (1.004–1.433)	0.0453
<b>Tiotropium+olodaterol 5/5 µg</b>				
<i>versus</i> tiotropium+olodaterol 2.5/5 µg	−0.662±0.545 [−1.731–0.407]	0.2249	1.189±0.108 (0.995–1.421)	0.0565

Data are presented as adjusted mean±se, unless otherwise stated. Data were obtained from fitting a mixed model for repeated measurements including fixed effects of treatment, planned test day, treatment-by-test-day interaction, baseline and baseline-by-test-day interaction; patient as a random effect; spatial power covariance structure for within-patient errors and Kenward–Roger approximation of denominator degrees of freedom. <sup>#</sup>: number of patients contributing to the mixed model for repeated measurements for adjusted mean SGRQ across both studies: tiotropium+olodaterol 5/5 µg n=979; tiotropium+olodaterol 2.5/5 µg n=990; tiotropium 5 µg n=954; tiotropium 2.5 µg n=960; olodaterol 5 µg n=954; <sup>¶</sup>: defined as having an SGRQ total score at week 24 ≥4.0-times better than baseline SGRQ total score. <sup>§</sup>: responder analysis results are from fitting a logistic-regression model with treatment as covariate and a logit link function; <sup>f</sup>: number of patients contributing to SGRQ responder analysis across both studies: tiotropium+olodaterol 5/5 µg n=979; tiotropium+olodaterol 2.5/5 µg n=990; tiotropium 5 µg n=955; tiotropium 2.5 µg n=960; olodaterol 5 µg n=954.

TABLE 6 Summary of adverse events: combined analysis (treated set)

	Olodaterol 5 µg	Tiotropium 2.5 µg	Tiotropium 5 µg	Tiotropium+olodaterol 2.5/5 µg	Tiotropium+olodaterol 5/5 µg
<b>Patients n</b>	1038	1032	1033	1030	1029
<b>All adverse events</b>	795 [76.6]	758 [73.4]	757 [73.3]	769 [74.7]	761 [74.0]
Treatment-related adverse events	69 [6.6]	62 [6.0]	63 [6.1]	62 [6.0]	73 [7.1]
Adverse events leading to discontinuation	103 [9.9]	90 [8.7]	93 [9.0]	57 [5.5]	76 [7.4]
Serious adverse events	181 [17.4]	156 [15.1]	172 [16.7]	168 [16.3]	169 [16.4]
Fatal	14 [1.3]	12 [1.2]	17 [1.6]	14 [1.4]	18 [1.7]
Life-threatening	3 [0.3]	5 [0.5]	2 [0.2]	5 [0.5]	5 [0.5]
Disabling/incapacitating	1 [0.1]	3 [0.3]	2 [0.2]	0 [0.0]	3 [0.3]
Requiring hospitalisation	162 [15.6]	144 [14.0]	155 [15.0]	149 [14.5]	153 [14.9]
Prolonging hospitalisation	12 [1.2]	10 [1.0]	3 [0.3]	7 [0.7]	6 [0.6]
Other	20 [1.9]	16 [1.6]	18 [1.7]	18 [1.7]	12 [1.2]
<b>Specific adverse events with an incidence &gt;3%</b>					
Respiratory, thoracic and mediastinal disorders	470 [45.3]	453 [43.9]	441 [42.7]	393 [38.2]	405 [39.4]
COPD	370 [35.6]	352 [34.1]	340 [32.9]	301 [29.2]	332 [32.3]
Cough	31 [3.0]	46 [4.5]	45 [4.4]	43 [4.2]	40 [3.9]
Dyspnoea	38 [3.7]	44 [4.3]	51 [4.9]	37 [3.6]	39 [3.8]
Infections and infestations	393 [37.9]	363 [35.2]	348 [33.7]	394 [38.3]	374 [36.3]
Nasopharyngitis	131 [12.6]	123 [11.9]	121 [11.7]	134 [13.0]	128 [12.4]
Upper respiratory tract infection	56 [5.4]	61 [5.9]	57 [5.5]	69 [6.7]	54 [5.2]
Pneumonia	36 [3.5]	24 [2.3]	26 [2.5]	31 [3.0]	34 [3.3]
Bronchitis	33 [3.2]	23 [2.2]	23 [2.2]	28 [2.7]	31 [3.0]
Gastrointestinal disorders	165 [15.9]	152 [14.7]	154 [14.9]	146 [14.2]	143 [13.9]
Diarrhoea	33 [3.2]	23 [2.2]	27 [2.6]	29 [2.8]	24 [2.3]
Musculoskeletal and connective tissue disorders	124 [11.9]	119 [11.5]	117 [11.3]	155 [15.0]	156 [15.2]
Back pain	35 [3.4]	23 [2.2]	19 [1.8]	40 [3.9]	37 [3.6]
Nervous system disorders	87 [8.4]	93 [9.0]	101 [9.8]	100 [9.7]	84 [8.2]
Headache	31 [3.0]	23 [2.2]	41 [4.0]	30 [2.9]	27 [2.6]
Vascular disorders	72 [6.9]	54 [5.2]	50 [4.8]	58 [5.6]	62 [6.0]
Hypertension	48 [4.6]	28 [2.7]	30 [2.9]	35 [3.4]	30 [2.9]

Data are presented as n (%), unless otherwise stated. COPD: chronic obstructive pulmonary disease.

clinical practice [1] due, in part, to the lack, until recently, of available FDCs of LAMA+LABA. Olodaterol is a novel once-daily LABA that has been designed as a combination partner for tiotropium, with matching pharmacokinetic and pharmacodynamic profiles [11]. Initial results have indicated that olodaterol may augment the beneficial effects of tiotropium in patients with COPD [21, 22].

The results of our trial are broadly similar with those reported for other LAMA+LABA FDCs [24–26]. However, comparisons between trials are inadvisable owing to differences in study design, including duration and patient population. Compared with those performed with indacaterol/glycopyrronium [24, 25], our studies included a higher proportion of patients with severe or very severe COPD; the fact that, in general, patients with lower lung function show smaller responses to treatment in clinical trials may explain why the increases with dual bronchodilator treatment were slightly lower. An earlier study with the FDC of tiotropium+olodaterol that included fewer patients with very severe disease showed larger effect sizes than the current studies [27].

Symptomatic benefit of the FDC was demonstrated by statistically significant improvements in mean SGRQ total score; compared with monotherapy, this was observed with tiotropium+olodaterol FDC 5/5 µg but not with 2.5/5 µg. Improvements in SGRQ that exceeded the minimum clinically important difference of 4 units for this measure were seen in all treatment arms, but the difference between the FDCs and the monotherapies did not meet this threshold [28]. Since there was no placebo arm, further analysis of the relevance of these improvements is limited. Responder analyses have been proposed as an additional approach to assessing efficacy of treatments in COPD, particularly for studies in which second and third

treatments are added to current therapy [28]. In our studies, responder rates, defined as a reduction in SGRQ total score of  $\geq 4$  units from baseline, were significantly greater for tiotropium+olodaterol FDC 5/5  $\mu\text{g}$  compared with its monotherapy components and for 2.5/5  $\mu\text{g}$  compared with olodaterol 5  $\mu\text{g}$ .

The doses of tiotropium and olodaterol used in these studies were based on previously published dose-response studies of this drug combination [21, 22]. In the latter, although a dose response for lung function was observed with increasing doses of tiotropium added to a fixed dose of olodaterol, the increase with tiotropium 2.5  $\mu\text{g}$  when added to olodaterol was smaller than the increase with 5  $\mu\text{g}$  when added to olodaterol [21, 22]. Overall, based on the results of the current studies and TIOSPIR, the optimum dose of tiotropium is considered to be 5  $\mu\text{g}$ , both as monotherapy and in combination with olodaterol.

The assessment of safety in our studies yielded no specific concerns in spite of the inclusion of a relatively large proportion of patients with GOLD stage 4 disease and a substantial proportion with co-morbidities. The number of adverse events in the arms with tiotropium+olodaterol FDCs were not higher than in those receiving the individual components; there was also no difference in incidence of adverse events with the higher and lower doses of tiotropium.

“Dry mouth” (typically associated with LAMAs) was reported as a side effect in <2% of patients, possibly attributable to the fact that the majority of patients included in these trials had previously received tiotropium. Additionally, there appears to be no increase in risk of experiencing either a MedDRA SOC “cardiac” or MACE with tiotropium+olodaterol FDC *versus* the mono-components, and no imbalances between treatment groups were seen in the subgroup of patients with a history of cardiac disease.

Our studies have several limitations. Firstly, there was no placebo group; it was considered inappropriate to deny patients with symptomatic COPD the use of even one long-acting bronchodilator in a study lasting 1 year. Furthermore, these studies were not designed to assess the impact of tiotropium+olodaterol on COPD exacerbations. However, the limited exacerbation data from these studies are encouraging and in line with results for other LAMA+LABA combinations [25]. Further studies powered to examine this end point are planned.

## Conclusions

These replicate studies confirm the efficacy and safety of once-daily dosing with tiotropium+olodaterol FDC as maintenance therapy in patients with moderate to very severe COPD (GOLD stage 2–4). The fixed dose of 5  $\mu\text{g}$  of each appears to be optimal in the combination, providing significant improvement in all three primary end points (trough FEV<sub>1</sub>, FEV<sub>1</sub> AUC<sub>0–3</sub> and health status) compared to tiotropium or olodaterol administered alone.

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## References

- 1 Tashkin DP, Ferguson GT. Combination bronchodilator therapy in the management of chronic obstructive pulmonary disease. *Respir Res* 2013; 14: 49.
- 2 Global Initiative for Chronic Obstructive Lung Disease. Global strategy for the diagnosis, management, and prevention of chronic obstructive pulmonary disease. Updated 2014. [www.goldcopd.org/uploads/users/files/GOLD\\_Report2014\\_Feb07.pdf](http://www.goldcopd.org/uploads/users/files/GOLD_Report2014_Feb07.pdf) Date last updated: 2014. Date last accessed: 2 June 2014.
- 3 Tashkin DP, Celli B, Senn S, *et al.*, for the UPLIFT Study Investigators. A 4-year trial of tiotropium in chronic obstructive pulmonary disease. *N Engl J Med* 2008; 359: 1543–1554.
- 4 Bateman ED, Tashkin D, Siafakas N, *et al.* A one-year trial of tiotropium Respimat® plus usual therapy in COPD patients. *Respir Med* 2010; 104: 1460–1472.
- 5 Cooper CB, Celli BR, Jardim JR, *et al.* Treadmill endurance during 2-year treatment with tiotropium in patients with COPD: a randomized trial. *Chest* 2013; 144: 490–497.
- 6 Yohannes AM, Willgoss TG, Vestbo J. Tiotropium for treatment of stable COPD: a meta-analysis of clinically relevant outcomes. *Respir Care* 2011; 56: 477–487.
- 7 Vogelmeier C, Hederer B, Glaab T, *et al.*, for the POET-COPD Investigators. Tiotropium *versus* salmeterol for the prevention of exacerbations of COPD. *N Engl J Med* 2011; 364: 1093–1103.
- 8 Wise RA, Anzueto A, Cotton D, *et al.*, for the TIOSPIR Investigators. Tiotropium Respimat Inhaler and the risk of death in COPD. *N Engl J Med* 2013; 369: 1491–1501.
- 9 Troosters T, Celli B, Lystig T, *et al.*, on behalf of the UPLIFT® investigators. Tiotropium as a first maintenance drug in COPD: secondary analysis of the UPLIFT® trial. *Eur Respir J* 2010; 36: 65–73.

- 10 Decramer M, Celli B, Kesten S, *et al.*, for the UPLIFT investigators. Effect of tiotropium on outcomes in patients with moderate chronic obstructive pulmonary disease (UPLIFT): a prespecified subgroup analysis of a randomised controlled trial. *Lancet* 2009; 374: 1171–1178.
- 11 Bouyssou T, Casarosa P, Naline E, *et al.* Pharmacological characterization of olodaterol, a novel inhaled  $\beta_2$ -adrenoceptor agonist exerting a 24-hour-long duration of action in preclinical models. *J Pharmacol Exp Ther* 2010; 334: 53–62.
- 12 Casarosa P, Kollak I, Kiechle T, *et al.* Functional and biochemical rationales for the 24-hour-long duration of action of olodaterol. *J Pharmacol Exp Ther* 2011; 337: 600–609.
- 13 Lange P, Aumann J-L, Derom E, *et al.* The 24-h FEV<sub>1</sub> time profile of olodaterol QD delivered *via* Respimat® in COPD: Results from two 6-week studies. *Eur Respir J* 2013; 42: Suppl 57, 982s.
- 14 Feldman G, Bernstein JA, Hamilton A, *et al.* The 24-hour FEV<sub>1</sub> time profile of olodaterol once daily (QD) *via* Respimat® and formoterol twice daily (BID) *via* Aerolizer® in patients with COPD: results from two 6-week studies. *Chest* 2013; 144: 749A.
- 15 Ferguson G, Feldman G, Hofbauer P, *et al.* Lung function efficacy of olodaterol QD delivered *via* Respimat® in COPD patients: Results from two 48-week studies. *Eur Respir J* 2013; 42: Suppl 57, 5s.
- 16 Koch A, Pizzichini E, Hamilton A, *et al.* Lung function efficacy of olodaterol QD delivered *via* Respimat® versus placebo and formoterol BID in patients with COPD: Two 48-week studies. *Eur Respir J* 2013; 42: Suppl 57, 146s.
- 17 Koch A, Paggiaro P, Hamilton A, *et al.* Symptomatic benefit of olodaterol QD delivered *via* Respimat® versus placebo and formoterol BID in patients with COPD: Combined analysis from two 48-week studies. *Eur Respir J* 2013; 42: Suppl 57, 145s.
- 18 Maltais F, Kirsten A-M, Hamilton A, *et al.* Evaluation of the effects of olodaterol on exercise endurance in patients with COPD: results from two 6-week studies. *Chest* 2013; 144: 748A.
- 19 Bouyssou T, Schnapp A, Casarosa P, *et al.* Addition of the new once-daily LABA BI 1744 to tiotropium results in superior bronchoprotection in pre-clinical models. *Am J Respir Crit Care Med* 2010; 181: abs 4445.
- 20 Bouyssou T, Casarosa P, Pieper M, *et al.* Synergistic bronchoprotective activity of the long-acting  $\beta_2$ -agonist olodaterol with tiotropium (long-acting M<sub>3</sub> antagonist) and ciclesonide (inhaled steroid) on the ovalbumin-induced bronchoconstriction in anaesthetized guinea pigs. *Eur Respir J* 2011; 38: Suppl 55, 613s.
- 21 Maltais F, Beck E, Webster D, *et al.* Four weeks once daily treatment with tiotropium+olodaterol (BI 1744) fixed dose combination compared with tiotropium in COPD patients. *Eur Respir J* 2010; 36: Suppl 54, 1014s.
- 22 Aalbers R, Maleki-Yazdi MR, Hamilton A, *et al.* Dose-finding study for tiotropium and olodaterol when administered in combination *via* the Respimat® inhaler in patients with COPD. *Eur Respir J* 2012; 40: Suppl 56, 525s–526s.
- 23 Global Initiative for Chronic Obstructive Lung Disease. Global strategy for the diagnosis, management, and prevention of chronic obstructive pulmonary disease. [www.who.int/respiratory/copd/GOLD\\_WR\\_06.pdf](http://www.who.int/respiratory/copd/GOLD_WR_06.pdf) Date last updated: 2006. Date last accessed: 5 March 2014.
- 24 Bateman ED, Ferguson GT, Barnes N, *et al.* Dual bronchodilation with QVA149 versus single bronchodilator therapy: the SHINE study. *Eur Respir J* 2013; 42: 1484–1494.
- 25 Wedzicha JA, Decramer M, Ficker J, *et al.* Efficacy and safety of QVA149 versus glycopyrronium and tiotropium in severe to very severe COPD: the SPARK study. *Am J Respir Crit Care Med* 2013; 187: abs A2429.
- 26 Celli B, Crater G, Kilbride S, *et al.* A 24-week randomized, double-blind, placebo-controlled study of the efficacy and safety of once-daily umeclidinium/vilanterol 125/25 mcg in COPD. *Am J Respir Crit Care Med* 2013; 187: abs A2435.
- 27 Derom E, Westerman J, Groenke L, *et al.* The 24-hour lung function profile of once-daily tiotropium and olodaterol fixed-dose combination compared with placebo and monotherapies in chronic obstructive pulmonary disease. *Am J Respir Crit Care Med* 2014; 189: abs 6727.
- 28 Jones PW. Estimation and application of the minimum clinically important difference in COPD. *Lancet Respir Med* 2014; 2: 167–169.